Community Health Partnerships Programme

Chikwawa District

12 Quarterly Report:

October - December 2000

Prepared for
CHIKWAWA Community Health and Partnerships

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1. ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BIMI	Blantyre Integrated Malaria Initiative
CBM	Community-based Management
CBDA	Community-based Distributor Agents
CDA	Community Development Assistant
CHAPS	Community Health Partnerships
CU	Concern Universal
DHMT	District Health M anagement Team
DHO	District Health Officer
DPMT	District Project Management Team
DRF	Drug Revolving Fund
DQAC	District Quality Assurance Committee
EBF	Exclusive Breast feeding
EDHMT	Expanded District Health Management Team
EPI	Expanded Programme on Immunisation
GMV	Growth Monitoring Volunteer
HESP	Hygiene Education and Sanitation Promotion
HSA	Health Surveillance Assistant
IEC	Information Education and Communication
IEF	International Eye Foundation
IMCI	Integrated Management Childhood Illness
LePSA	**Le**arner centred **P**roblem posing **S** elf discovery **A**ction oriented
MCH	Maternal Child Health
MOHP	Ministry of Health and Population
NGO	Non Governmental Organisation
NLS	National Library Service
ORT	Oral Rehydration Therapy
PHAST	Participatory Hygiene and Sanitation Transformation
PHR	Partnership for health Reform
QA	Quality Assurance
QITs	Quality Improvement Team
RCIC	Rural Commu nity Information centres
SMI	Safe Motherhood Initiative
STD	Sexually Transmitted Diseases
SUCOMA	Sugar Company of Malawi
TfT	Training for Transformation
TOT	Training of Trainers
VHC	Village Health Committee
VHWCs	Village Health Water Committee (s)
VLOM	Village Level Operation Maintenance
WES	Water and Environmental Sanitation

2. EXECUTIVE SUMMARY

This report describes the activities carried out in this quarter (October - December 2000) under the Chikwawa Community Health Partnerships (CHAPS) programme by the International Eye Foundation (IEF) and Chikwawa District Health Office (DHO). Other important stakeholders in the district including SUCOMA (Sugar Company of Malawi), Ministry of Education, Sports and Culture, Ministry of Agriculture and Irrigation, Ministry of Gender Youth and Community Services, and Concern Universal were also involved in project activities.

The report summarizes project's achievements, lessons learned and challenges. Activities planned for the forthcoming quarter has been summarized at the end of this report. In the quarter, progress of the activities were slowed down for reasons beyond the Project.

As part of the World AIDS Day commemoration, the district conducted the commemoration in traditional authority Ngabu where approximately 1,100 people were present. The activities included: drama performance, debate, panel discussion, quiz and open question sessions.

The district conducted baseline assessment of the Integrated Management of Childhood Illness (IMCI) in twenty-seven health facilities in the district. Limited time available for individual patient's consultation was a major constraint for IMCI implementation. The report includes discussions and recommendations for the assessment in the main text.

A follow up visit for the financial management was done in the quarter. Progress of the recommendations done in the initial visit of the consultant were discussed with the District Health Management Team. Quality Assurance Coaches attended a refresher training in Salima that the Quality Assurance Project Specialists organised. Coaches discussed new approach of problem identification. The Specialists visited 4 district Quality Improvement Teams in the quarter.

Assessment of the first 20 Adult Literacy learners that focuses on HIV/AIDS and Family Planning messages were conducted in the quarter. The Project registered a total of 323 women at the beginning of the classes. Preliminary results show that 154 (48%) were literate after the assessment. However, 295 women attended 91% of classes that exceed the project target of 200 women attending 80% of the classes.

Water and Environmental Sanitation activities continued to progress in the quarter despite most of the community members being busy in agricultural field. Village Health Water Committees (VHWCs) were fully active in WES activities that saw twenty-seven VHWCs receiving initial training.

Supervisory visits were done to twelve trained DRFs. During the supervision positive areas were noted which included: accumulation of enough money to revolve the drugs, opening of Savings Account, and turn up of patients especially for malaria treatment.

A total of 180 farmers from twelve villages had received 1440 kg soya and 3840 kg groundnuts for seed exchange programmes for the promotion of oil rich food. Farmers from eight villages were trained in nutritional and food preservation by using solar driers. The project distributed a total of 390 fruit trees (200 pawpaws, fifty-five guavas, forty-eight mangoes and eighty-seven cashew nuts) to six villages. The CHAPS districts jointly conducted training of Trainers in syndromic management for sexually transmitted diseases. Three participants from Chikwawa successfully completed the 2-week training.

3. INTRODUCTION

This report describes activities carried out under the Community Health Partnerships Programme in Chikwawa District from October - December 2000. As previously all activities were carried out jointly

by the Ministry of Health and Population (MOHP) - Chikwawa District Health Office and the International Eye Foundation as main partners, involving other important stakeholders such as St. Montfort Hospital and SUCOMA. A brief description of the activities planned for the next quarter is included in this report (January - March 2001).

The onset of rains in the reporting period was earlier than what we have experienced in the past years. This change in rainfall forced the communities to be engaged in agricultural activities, therefore Project activities were at a slow pace.

4. MAIN ACTIVITIES AND ACHIEVEMENTS

4.0 CAPACITY BUILDING

4.1 Information Education and Communication

Chikwawa District had commemorated the World AIDS Day on 17 December 2000 in Traditional Authority Ngabu that has a total population of 117,905. Soapa village was selected as a venue of the activities. In line with this year's theme "Men and AIDS - a gendered approach" several activities were displayed and both the panelists and the participating community members answered questions jointly. Activities conducted included four drama performances, debate, panel discussion, quiz and open question sessions.

Approximately 1,100 people from the surrounding villages attended the function. It was really very interesting as more community members participated and the event took place in a remote area. Some main issues brought up by the community members and discussed as part of the panel discussion, debate, quiz and question sessions were:

- Involvement of men in the care for sick patients or family members
- Condom use by men having sexual intercourse with bar women at bars, bottle stores, rests houses
- Unsafe cultural practices prevalent within Chikwawa District, e.g. remarriage of a wife by brothers or family members upon death of the husband - linked to this issue Voluntary Counselling and Testing was discussed
- Free discussion of sexual health matters within a family

The Chikwawa Chief Executive, the District Health Officer, Traditional Authority Ngabu, Political Leaders attended the function. The dignitaries had spoken on the importance of the commemoration of the day and the fight against HIV/AIDS epidemic. Several heads of Government Departments and representatives of NGOs, i.e. Banja La Mtsogolo and World Vision International also attended the function. The representation of the people showed the multi sectrol approach in the fight against the epidemic.

As part of the Youth Club Competitions, final competitions were conducted in the quarter. Six clubs participated in this final round where prizes were awarded to winning clubs. The aim of conducting these competitions among the youth is to encourage them in taking part in disseminating HIV/AIDS messages to the community. Secondly, to educate the youth on behaviour change towards HIV/AIDS infection among the youth.

4.2. 1. Integrated Management of Childhood Illness (IMCI) Baseline Assessment

The IMCI baseline assessment on the management of the childhood illness was conducted in the District from March through April 2000. The objectives of the assessment were: to provide baseline

information about outpatient services provided for children under five years of age at health facilities in Chikwawa District before district wide implementation of the IMCI programme and to allow adequate monitoring and evaluation in the future.

ASSESSMENT METHODOLOGY

Consultation with the Blantyre District Team (Blantyre Integrated Malaria Initiative - BIMI) and the CHIKWAWA EDHMT representative was held where tools used by BIMI were shared. The establishment of a District IMCI Working Group followed this. The working group conducted a meeting where data collection tools were selected as:

Assessment of Workload and Staffing Patterns
Observation of Health Workers Consultations
Exit Examinations by IMCI Examiners
Mother / Caretaker Exit Interviews

Training of the Assessment Team and Supervisors was conducted before the beginning of the assessment.

RESULTS OF THE ASSESSMENT

27 health facilities providing services for children under five years of age visited (total of thirty health facilities in the district)
695 consultations for children aged 2 months up to 5 years observed
669 exit examinations performed
668 mothers or caretakers interviewed

Health Facility Workload and Staffing Patterns

Number of children seen per day:

According to health facility monthly reports

CHIKWAWA District Hospital: around 100 children / day
St. Montfort Hospital: around 25 children / day
Health Centres: average of 40 children / day

During the health facility assessment

Average of 25 children / day
Maximum of 45 children / day
(5 facilities with 40 - 45 children / day)

Staffing patterns:

In most units all tasks related to care for the sick child were done by one person, usually the medical assistant. The majority of units did have two 'clinical' staff available, usually one medical assistant and one nurse.

Some training gaps were identified:

Large number of health workers were trained in, e.g. family planning, syndromic STD management and few health workers trained on, e.g. HIV/AIDS, tuberculosis case management, and EPI. It was noted that health workers from private health facilities had undergone less training than MOHP staff.

Observation of Consultations for Children

Comparison with Exit Examinations

Average duration of consultation observed was 2 - 3 minutes, with around 75% of the children seen in less than 5 minutes. Most health workers did not assess children for danger signs. Only very few health workers were observed to undress children and perform a complete physical examination.

Comparison of health worker's and IMCI examiners' diagnosis:

Diagnosis	**Health Worker**	**IMCI Examiner**
Malaria	56%	84%
Cough or difficult breathing	23%	60%
Diarrhoea	9%	29%
Anaemia	4%	23%
Ear infection	2%	7%
Malnutrition	1%	7%

Drug prescriptions:

Only few drug shortages were observed and most drugs prescribed were issued to the child's mother right after the consultation. In around 40% health workers made mistakes when prescribing drugs, e.g. Wrong frequency or duration of treatment prescribed.

Of sixty-five of children suffering from a severe or a chronic disease that required hospital management, only thirty-seven were referred to the hospital by the health workers.

Communication and counselling skills:

Counselling skills of health workers observed were poor, as shown by, e.g.: Only around 40% of the health workers greeted the mother and around 30% informed the mother about the child's diagnosis. Very few health workers provided advice about danger signs or feeding during the child's illness. Around 70 - 75% of the mother were not able to recall the correct frequency and duration of treatment prescribed when interviewed right after the consultation.

Mother or Caretaker Exit Interviews

The majority of the mothers stated that they would return to the same health facility if the child's condition did not improve. It was also noted that mothers were found to have some basic understanding about danger signs and when to return with as child to the health unit immediately. Follow-up requirements for the sick children were not always fully understood. When mothers were asked the preferred time to bring their sick child to the hospital, most mothers opted to bring a sick child to the health facility in the morning, however upon probing mothers would want their child to be seen when possible once the child is sick. Reasons given for the options were that some health centres were either closed or not fully operational during afternoon hours.

Around 40% of the mothers prefer drug injections, mostly because they believe that these are stronger, more effective and work faster. Around 25% preferred tablets for easy administration and because they were effective. Around 20% had no preferences, but trusted and would follow the health worker's prescription.

DISCUSSION AND RECOMMENDATIONS

Limited time available for individual patient's consultation was as a major constraint for IMCI implementation. Re-organisation of the patient-flow and better task distribution could help with a suggestion of the involvement of IMCI trained nurses in provision of outpatient consultations for children. Training and increased involvement of HSA's and health centre support staff in tasks such as:

Checking children in the waiting rooms for danger signs
Measurement of temperature and weight

Administration of first doses and explaining treatment prescribed to the mothers
Counselling of mothers on, e.g. danger signs, follow-up requirements, exclusive breastfeeding, feeding during and after a child's illness
Management of ORT corners

Improved distribution of workload over the day: ensure that health facilities are open and fully operational during afternoon hours.

It is also anticipated that if IMCI protocol is followed properly and conscientiously, will assist health workers

- To systematically check for danger signs
- Not to overlook main signs or symptoms
- To ensure that all problems present are being assessed , classified and treated during the initial visit
- To prescribe correct treatment as simple flow-charts and tables for first and second line treatment are being provided
- To ensure that children with severe or chronic conditions are being identified and referred

Improved counselling of mothers and other caretakers will contribute to:

- A better understanding of childhood illnesses, prevention and control by mothers

- Early identification of danger signs by caretakers and early care seeking behaviour
- Increased compliance regarding administration of medication at home as well as home management in general
- Improved compliance with follow-up requirements
- Promotion of exclusive breastfeeding for infants and a balanced diet for children that in turn will contribute to prevention and reduction of malnutrition among children

Importance of support from district to health centre level:

- Training of health workers on IMCI case management at district level
- Training of support staff at health centre level
- Supervisory visits from district supervisors and facilitators:

  Training of health centre in-charges on supervisory skills
  Assistance with re-organisation of clinics, development of health centre work plans
  Performance of observations of consultations during supervisory visits
  Provision of feedback from supervision and referral cases

- Development and dissemination of job aids and health education materials
- Continuous and adequate drug supply

4.2.2. IMCI training, orientation and work plan

In order to build the capacity at the District level to effectively implement IMCI, 4 participants were identified as possible facilitators during the IMCI case management training that was held in Blantyre. One participant (Dr.T. Dacruz - District Health Officer) was sent to Kenya and successfully trained as a Facilitator. This brings a total of 3 facilitators for the district. Plans are underway to train 4 more facilitators who are anticipated to facilitate IMCI training in the district.

Orientation of the district stakeholders on IMCI activities was conducted in quarter. The National IMCI Co-ordinator supported the orientation. The purpose of the orientation was to create awareness on IMCI protocol for the management of sick children and to solicit support on the implementation of IMCI in the district from other stakeholders. With IMCI community component, the stakeholders are anticipated to support the implementation.

Following the orientation, a review of the IMCI Task Force was done which included important stakeholder representatives, i.e. Agriculture, Community Services and Concern Universal. The Task Force is anticipated to develop a work plan that will be presented to the management for recommendations.

Development of the IMCI work plan (January 2001 - June 2002) is anticipated to be completed in the forthcoming quarter.

4.3. Financial Management

A follow up visit by the Financial Consultant from Partnership for Health Reform (PHR) - Mr. Steve Musua was conducted in the quarter. Most of the recommendations that were made by the Consultant during his first visit had been implemented and functional, i.e., necessary ledgers to

control the budget by line item to monitor expenditure, use of the accounts soft ware "Quicken" for budgetary control and monthly reporting, and on job training of the accounts staff on computer skills.

Schedule to train the District Financial Committee on QA concept has been drawn as per consultant recommendations. This training will equip the committee members to use the QA problem cycle for solving any financial problems. The consultant had recommended the district to use the current quicken financial package since it is a user friendly. Sojourn to identify a proper accounting package had proved a failure. The financial packages currently on the market were quite expensive and not user friendly.

4.4.Quality Assurance

Chikwawa Quality Assurance Coaches attended refresher training in Salima. The goal of the training was to develop the coaching and team building skills for the QA coaches in order to support the established Quality Improvement Teams. The Chikwawa coaches presented a Fleet Management progress which QA concept was utilized for the improvement of the Government fleet.

The problem statement for Chikwawa fleet management was: There is a problem of lack of transport for carrying various district health activities. The current situation is that scheduled supervisory trips not done, dead bodies not being transported in time, essential drugs not delivered in health centers. The problem has existed for a long time but documentation is available from 1996. An improvement will result in having an adequate of vehicles available to carry out basic district health activities.

Following the district commitment on the fleet management, positive improvement had been noted which included: regular supervisory visits to health facilities, dead bodies not taking long in the mortuary and essential drugs delivered in the health facilities on time.

The major area that brought a hot discussion was on the identification of the problem that teams are required to work on. As traditionally, teams were supposed to identify their own problem faced. However, the new approach requires the DHMT to identify the service/clinical focus area, i.e., family planning for teams to focus their problems of concern.

The Quality Assurance Project Specialists (Mrs. Melina Mchombo and Mr. Gumbo) visited the district in the quarter. They visited 4 Quality Improvement Teams at Gaga Health Center, Makhwira Health Center, Mapelera Health Center, SUCOMA and Chikwawa District Hospital team 1 representatives. After the visit, the Specialists briefed the district on their findings and recommendations for the improvement on the QA process.

5.0. PROGRAMME INTERVENTIONS

5.1. Adult Literacy (linked with HIV/AIDS and Family Planning)

Adult Literacy Classes Assessment:

Adult Literacy Component of the Community Health Partnerships Programme (CHAPS) for CHIKWAWA District started in early 1999. In view of high rates of illiteracy especially among women in CHIKWAWA, confirmed by the findings of the CHAPS Community Baseline Survey with 62% of the women interviewed who had never attended school, a programme combining adult literacy

activities for women with health education on family planning and HIV / AIDS prevention was developed and implemented. Initial target outlined in the CHAPS project proposal was for 200 women to have attended at least 80% of all classes of a female adult literacy class by the end of the project.

This report will describe and discuss the preliminary results of the final examinations of the first 20 adult literacy classes which took place in July and November 2000, observations made during classes and supervisory visits will also be included, as they provide important insights regarding the health education component of the programme. The final report of the assessment will be finalised in the forthcoming quarter

Collaboration

At district level, the following staff were fully involved in the discussions and planning of the CHAPS adult literacy activities: District Adult Literacy Co-ordinator
(Ministry of Gender, Children and Community Services), District HIV/AIDS Co-ordinator, District Family Planning Co-ordinator, CHAPS Training/ Quality Assurance Advisor, Female MCH Co-ordinator and CHAPS Adult Literacy Co-ordinator.

Staff fully involved at the community level were: CHAPS Adult Literacy Co-ordinator, Community Development Assistants (CDAs), 20 literacy class instructors, Village Adult Literacy Committees as well as the HIV/AIDS and Family Planning and the Female MCH Co-ordinator as supervisors.

Adult Literacy Curriculum

The Government Standard Curriculum was reviewed at the workshop that was conducted in May 1999. In this curriculum, nothing was changed. The additions that were made in the curriculum were messages on HIV/AIDS and Family Planning. The topics that were included in the curriculum to address the CHAPS Adult Literacy Programme objectives were:

☞**HIV/AIDS:** Definition, its prevalence, modes of transmission, risk and non risk behaviours, prevention, signs/symptoms, living positively with HIV/AIDS, home based care and sexually transmitted diseases.

☞ **Family Planning:** Definition, benefits, risks groups, outcome of overpopulation in relationship to culture and economic status, family planning methods.

Assessment Methodology

The Government tools for assessing the adult literacy learners were used in this programme. However, the District Adult Literacy Task Force had changed the pattern of assessing the learners on the IEC component of HIV/AIDS and Family Planning messages besides assessing literacy skills (reading, writing and simple arithmetic)

Summary of Activities

The following table outlines the main activities carried out under the adult literacy programme since the starting of CHAPS activities in CHIKWAWA in April 1998.

Summary of Activities of the CHAPS Adult Literacy Programme

TIME	ACTIVITY
1st January, 1999	Recruitment of CHAPS IEF Adult Literacy Co-ordinator
March, 1999	Establishment of Adult Literacy Task Force
10 - 14 May, 1999	Planning and Curriculum Development writing workshop for CHAPS Adult Literacy Programme.
June, 1999	Selection of 20 sites for Adult Literacy classes
July, 1999	Training of Adult Literacy Class Teachers, District HIV/AIDS and Family Planning Co-ordinators on Training of Transformation (TfT)
July, 1999	Registration of 323 women as adult literacy students.
4 - 8 October, 199	Training of 20 literacy instructors on integration of HIV/AIDS and Family Planning messages.
August 1999 - May 2000	Training of Adult Literacy Committees at community level.
August 1999 - June 2000	Supervision of the performance of adult literacy classes.
March 2000.	Mid term evaluation carried out by the Regional Development Officer.
22 - 24 May, 2000	Training of Community Development Assistants (CDAs) as adult literacy programme supervisors.
5-23 June, 2000 From 3 July, 2000	Training of 10 more Adult Literacy Instructors 200 women registered in the 10 Adult Literacy Classes going Literacy lessons up to April 2001(10 months period).

TIME	ACTIVITY
July - September, 2000	Final examinations for 20 adult literacy classes (including marking).
December, 2000	Training of 20 Community Information Assistants on management of rural libraries in the 20 literacy centres.
From January, 2001	Rural Information centres (Rural libraries) in operation.

Results of Adult Literacy Class Assessment

A total of 20 adult literacy classes were started in August 1999 and completed the curriculum in June 2000. A total of 323 women were registered as adult literacy students at the beginning of the classes. A first round of final assessment took place in July 2000 and was attended by 235 women, i.e. 73% of the women enrolled. 122 learners passed (were declared literate) representing 61% of the planned target but 52% of the total number which was enrolled.
However a number of problems were encountered during the performance of the assessment. These included:

- 88 women (27%) had not attended the assessment: Field visits were carried out to assess why women did not attend the assessment. A number of women indicated either having being busy in the fields or having attended to a sick person at the time of the assessment. It was also learnt from the instructors that most women who did not attend were afraid of the actual assessment.

- Changes of dates for final assessment were made and not communicated to students at Machado village. This may have contributed to 8 women from this village not attending the examination.

- Although 10 out of 16 women enrolled at Mtayamanja village had presented for the examination, the centre was disqualified, as the instructor had not followed proper examination procedures. It was discovered that he was writing for the learners instead of leaving them to write what they know.

Because of the important number of women not presenting for the assessment, the District Adult Literacy Task Force decided to conduct a second round of assessment allowing women to participate for those who did not attended the first round.

Second assessment was carried out in those villages where 5 or more women had not attended the first assessment, i.e. a total of 10 villages.

Results of the second round of the examinations and final results

A total number of 60 learners attended this assessment from 10 classes. Out of 60 who sat for the assessment in the second round, 32 passed. The passing number added to the 122 learners, who passed in the first round, gives a total of 154 learners who are now declared literate out of 295 learners who have been assessed. Based on the target of 200 women to be literate by the end of the project, 77% (154 women) have been declared literate. From the number that was enrolled (323), 28 learners (9%) have not been assessed. A total number of 295 women (91%) had attended the assessment out of 323 women.

Factors that lead to learners failure

It was established from the Instructors that there was frequent absenteeism amongst the majority of women who were not successful. This was also verified from the registers that are kept by the Instructors. This was a major reason that contributed to the high number of failures.

Time of supervision offered to these classes was so minimal. This was attributed due to the fact that it was hard to visit some of the classes due to impassable roads during the rainy season. Hence, it was difficult to monitor and assist the Instructors whether assistance was needed.

42% of the learners had poor skills in writing. This was observed during the assessment that most learners left blank on the part of comprehension that required learner's writing skills.

LePSA Approach as the Instructors teaching methodology

Prior to the set up of the 20 Adult Literacy classes, training was conducted for the Adult Literacy Instructors on the LePSA teaching methodology. The Instructors that CHAPS Project used were the ones that are currently being utilised by the Malawi Government in Adult Literacy Programme. LePSA Adult teaching process has the following advantages.

- Learners learn more from developing own ideas than listening to someone.
- Together, learners have vast pool of experience from which they learn.

LePSA word is delivered from the abbreviation word Le - P- S- A

Le= Learner Centred (Climate setting). This is where the instructor build relationship with her/his learners by greetings and call them by names; promote equity by sitting in a circle, seating arrangement enable each to have eye contact with everyone else; and use learners experience and vary methods of teaching e.g. buzzing, group work etc

P= Problem posing (Starter). This is where the instructor uses the following questions: The questions are guided by special "SHOWD" questions. e.g. (i) What did you see and hear? (ii)What was happening or what was the problem? Different types of starters used in CHAPS Literacy classes include: role-plays, songs, case studies, and poems, story pictures, proverbs and riddles.

S= Self discovery(Problem analysis) This is where the instructor uses the following questions which are also guided by "SHOWD" questions such as (iii) Does this happen in our community? (iv) Why does it happen?

A= Action - Oriented (Solutions). Learners on their own discuss solutions to overcome the problem by asking themselves: What can we do about it?

The results to the Learners after LePSA training:

Learners have acquired wide experience from their fellow learners. This was observed during discussions on the problem identified as learners shared their experiences to come up with possible solutions.

It has made the learners to contribute their own ideas/topics within their environment/culture for the

next lessons to be covered from their discussions. This was noted from the learner's contribution towards the next topic to be covered. Learners were able to choose a topic to be covered by the Instructor.
This approach has encouraged learners to full participation in the topics as learners are encouraged to contribute through the discussions basing on their experience.

The method has also made instructors to respect learners' views. This learning methodology, prepares the Instructors to learn from the students and capitalise the lessons from the learners views rather than instructors imposing views.

Results of IEC Components

The comprehension passage of the assessment, assessed learners on definition of AIDS and benefits of Family Planning. 123 learners (42%) of those who were assessed left these questions blank. They did not write anything which translate that they were unable to write though they heard the question clearly from the Instructors who were administering the assessment. Out of 295 learners, 172 learners (58%) who were able to answer the definition of AIDS, 151 learners (88%) answered it correctly.

On Family Planning question which asked them to pick two answers from the passage on benefits of family planning: Out of 172 learners who were able to write, (52%) were able to give two or more benefits of family planning.

Observations from classes and supervision

The HIV/AIDS and family planning messages passed in the adult literacy classes as well as the training for the adult literacy committees had an impact on the people's attitudes. They have positively contributed to the reduction of risky practices that contribute to the spread of HIV/AIDS and have accepted willingly practising family planning modern methods.

After some village headmen were transformed on HIV/AIDS messages and prevention, they are now discouraging people in their villages to stop the practice of death cleansing(kulowakufa). They emphasise widows not to be given a man to sleep with but instead be given herbs (Khundabwi) which also act as a death cleansing if sexual intercourse can not be done.
Discussions and recommendations

As it was observed that there was so minimal supervision , recommendation is made for joint supervision with all partners (Ministry of Gender ,Youth and Community Services plus Ministry of Health and Population) to be carried out so that each instructor should have a chance of being supervised at least once in every month. Holding review meetings quarterly with instructors where different issues concerning the strength and weaknesses could be discussed. Consideration of sites for the opening of classes should be critically decided. This will allow supervisors to follow up the Instructors to see their work. This was observed as most of the roads to the sites were impassable which also contributed to the minimal supervision.

In some of the classes where adult literacy committees were formed and trained, most of the learners managed to pass the assessment. It is there recommended that Adult literacy committee members be trained in AL concept so that they should encourage women to attend classes regularly.

To motivate more women to join the adult literacy classes, certificate presentation to successful learners should include presents/gifts to the best top three learners and simple gifts to all who have passed.

Since a good number of learners did not do well on written skills, the Instructors to spent much time with the learners on writing skills as observed from the results of the 42% learners who were not able to write.

Post Adult Literacy activities:

As part of the mid term review of the Adult Literacy Programme, recommendations were made to carry out post adult literacy activities for the first 20 classes. One of the areas recommended, was the establishment of Rural Community Information Centers (RCIC) with an aim of keeping the learners literate despite the closure of classes. Collaboration was done with the National Library Services (NLS) to set up these 20 Rural Information Centers. A training of 20 Instructors was conducted in the quarter that was facilitated by staff from National Library Services. At the end of the training, Instructors were issued with various type books to open these centers. The books were supplied by the National Library Services. The NLS had indicated that they will assist in the supervision of the centers and provision of additional books whenever available.

5.2. Water and Environmental Sanitation (WES)

During the reporting period, Government extension staff and Concern Universal (Sub contracted to carry out CHAPS WES activities) held community mobilization meetings to create awareness to communities. The mobilizations were held in 27 villages and lead to formation of 27 Village Health Water Committees (VHWCs). Training to communities in Hygiene Education and Sanitation Promotion (HESP) and Community Based Management (CBM) in order to build capacity at community level for hygiene and sanitation promotion was conducted. A total of 27 VHWCs received initial training that comprised 270 community members (152 women and 118 men).

In hygiene promotion, the Project continued to utilize various information, education and communication (IEC) tools including drama, band performances, focus group discussions and village exchange visits. This aimed at promoting behavioral change in hygiene and sanitation. Thirty-three sessions of hygiene education were conducted in target villages using trained band and drama groups, and focus group discussions. Village exchange visits were carried out in eight villages. This aimed at exchanging ideas, skills and observes HESP/CBM activities being carried out in the neighboring villages. Group discussions were conducted that looked at progress of activities in the village, problems being faced, actions being taken to address the issues.

The combined use of band performance, exchange visits and the use of PHAST tools have led to community members becoming more aware of the need for improved sanitation and hygiene practices to prevent water and sanitation related diseases. A total of 915 new traditional pit latrines were constructed and are in use by community members. 907 traditional pit latrines were improved with the installation of San plats and dome shaped slabs. 320 hand washing facilities were installed close to pit latrines, 575 new refuse pits, 1095 new bath shelters and 506 new dish racks were constructed. Three VHWCs constructed brick fence around their water points to keep animals away.

To increase access to safe and portable water to communities through their involvement and participation the following activities were undertaken during the quarter: 81 VHWC members (54 women and 27 men) received training in simple pump maintenance. The pump caretakers who were trained in major Afridev hand pump maintenance (CBM second phase) gave maintenance to 15 boreholes which involves rectifying major parts of the borehole.

In the quarter, 19 VHWCs established borehole maintenance fund, 24 VHWCs purchased fast wearing borehole spare parts for simple pump maintenance and 9 VHWCs opened Saving Accounts to safely keep their surplus money.

To monitor the progress of the WES activities, thirty-nine intensive follow up were carried out. During the visits, CU field staff and members from the District Project Management Team (DPMT) held discussions with beneficiary communities and extension staff responsible for those villages. Monthly coordination meetings with stakeholders were conducted in the quarter

Lesson learnt:
The ability to carry out major maintenance of boreholes by community Pump Caretakers clearly demonstrates the effectiveness and success of the second phase CBM training conducted during the previous quarters. With availability of borehole spare parts, the trained caretakers may sustain the maintenance of boreholes beyond the CHAPS Project.

Challenges:

Despite the willingnes s of the caretakers to assist in borehole maintenance, availability of spare parts in the district and the country as whole still remains a challenge.

5.3. Drug Revolving Funds

Follow up visits were conducted to established 12 DRFs in the quarter. A number of observations were made during the supervision that included:
☞Improper usage of patient registers that could not determine the quality of treatment or services offered to clients (patients)
☞DRF funds were used to run other programmes, i.e., nutrition that would lead to the death of DRFs as eventually DRFs will not have funds to procure drugs considering the hike prices of drugs on the market. Following these observations, meetings were held and solutions suggested t o the DRF committees and volunteers to properly manage the centers.

- DRFs had accumulated enough funds to revolve the centers and some had opened Savings Account to keep surplus money
- The dispensers had registered more malaria patients than any other ailment. Overall patient turn up was so positive for the purpose of setting up DRFs in remote areas.

To improve the services offered to DRF, tools to monitor the progress of DRFs were developed by the District DRF Task Force. The extension staff based in the DRF villages will complete the forms. The extension staff are required to submit the reports on quarterly bases to the District Health Office (DRF Coordinator)
Lesson learnt:

Wherever only one dispenser was trained not even a committee, there were problems identified. One of the problems was misappropriation of funds since there was no committee to monitor the dispenser. It was also very difficult to replace the dispenser since there was only one trained dispenser. Hence the potential opportunity to utilize a VHC member to dispense drugs if trained might be very useful for the continuity of the services.

5.4. Nutrition/Food Security

Farmers have been supplied with vegetable seeds to establish backyard gardens to promote vitamin A at community level. 180 farmers from 12 villages received the seeds and watering cans. Some of the seeds that were distributed included: Okra, Pumpkins, Carrots, Eggplants, Jews marrow, Cat whiskers and Amaranths. As a seed exchange programme to promote the growing of oil rich food, 3,840 kgs of groundnuts were distributed to 12 villages (480 farmers) and 1,440 kgs of soya to 10 villages (360

farmers). The criteria used to supply seeds to farmers were availability of children between 2 - 5 years of age. Consideration was taken to identify the 10 villages for soya as in some villages it has proved a failure for a number of times due to unfavorable conditions, i.e., soil nature.

Nutritional and food preservation training by use of solar dryers was conducted to 8 villages. The purpose of the training is to build the capacity within farmers to preserve vegetables and fruits whilst they are in abundant for future use. Research has shown that the use of solar dryers has an advantage that fruits or vegetables do not loose much of nutritional content as opposed to the other methods of food preservation.

Distribution of fruit trees that included paw paws, guavas, mangoes and cashew nuts was conducted to 6 villages. A total of 390 fruit trees have been distributed to these villages. The Project target is to assist farmers to successfully grow 500 fruit trees by the end of the Project. The distribution continues in the next quarter to the remaining 6 villages.

5.5. Primary Eye Care

The District conducted an eye camp in the quarter. The camp was possible due to a number of patients that were identified by the trained extension workers (HSAs) and Traditional Healers. They have been able to identify patients with poor vision and were referred to the health facility for further assessment. Out of the 295 patients who were screened, 44 cataract patients were identified. Surgeons from Queen Elisabeth Central Hospital with assistance from Chikwawa Ophthalmology staff conducted surgery for the 44 patients. Vision on discharge for the patients were further screened and came out as follows: 13 patients with vision between 6/6 - 6/18, 20 patient's vision between 6/18 - 6/60, 11 patients with vision below 6/60.

5.6. HIV/AIDS/STD

A training of 3 trainers in the syndromic management of sexually transmitted diseases was conducted in Blantyre. A total of 15 participants drawn from the CHAPS districts, Ntcheu, and Balaka attended the training that was facilitated by the National AIDS Control Programme. The training was organized in order to build the capacity within CHAPS districts. As it was noted that identifying Trainers from other districts to run a course was so difficult considering the workload in the districts. Hence, a joint training was sought to be conducted. A descriptive report will be submitted by the Facilitators to all the districts.

A workshop on Mother to Child Transmission (MTCT) of HIV/AIDS that was organized by Umoyo Networks was attended by 2 participants from Chikwawa. The participants after the training are ready to share the experience with the district on MTCT activities. It is therefore anticipated that once enough funds are available in the CHAPS extension, activities under MTCT will be implemented in the district.

The District Reproductive Health Coordinator attended a 4-week training in Kenya. The training focussed much on the management of reproductive health activities in general. An action plan has been developed that will require support from the DHMT for implementation of the planned activities.

6.0. Acknowledgement

I would like to extend my sincerely thanks to the District Health Officer for allowing the District Coordinators to carry out the CHAPS activities despite their tight schedule. The National AIDS Control Programme for identifying the Trainers for the Syndromic Management TOT to be conducted

for the CHAPS district which IEF coordinated the training. The team that conducted the Adult Literacy assessment, to them good job done. Let me also take this opportunity to thank the IEF Coordinators for the good job done with the district counterparts. Special thanks to the IEF Technical Advisor and the Country Director for their usual guidance.

7.0. WAY FORWARD (JANUARY - MARCH 2001)

7.1 Capacity Building

Area of intervention	Planned activities
Supervision	A training of 20 supervisors will be conducted. The supervisors will be drawn from the district hospital and health centres. Supervision was one of the priority areas identified during the QA assessment of 1998. After the training, a Task Force will be set to review and develop the district supervisory tools aiming at integrating the supervisory tools. Installation of a radio at Misomali Health Centre is planned in the quarter which is one of the CHAM units to facilitate communication
Construction	Provision of outreach shelter furniture, i.e., examination tables, benches and curtains to the 13 completed shelters ready for use and hand over to the community.
Integrated Management of Childhood Illness	Development of the IMCI work plan is sought to be finalised in the quarter by the District IMCI Task Force
Quality Assurance	Follow up visits to the 10 QITs has been planned and tracking forms to monitor team's progress is planned. One QIT will be formed in the quarter
Planning	Retreat for the CHAPS implementors is planned in the quarter to discuss project activities progress, challenges, and lessons learnt

7.2 Programme interventions

Area of intervention	Planned activities
Reproductive Health	Quarterly meeting for the district Family Planning Providers to review progress of family planning activities Provision of materials to the trained 96 CBDs that will enable them to effectively offer FP services to their clients
Nutrition/Food Security	Supervisory visits to 180 farmers practising backyard gardens, 480 groundnut farmers and 360 soya farmers is planned in the quarter Training of farmers, GMVs and HSAs on soya utilisation. This will prepare farmers to know how to prepare soya after harvest to get the required nutritional values, i.e., vitamin A Procurement and distribution of sweet potato vines for the 12 villages. The vines are the improved variety that has abundant vitamin A contents
Exclusive Breast Feeding and ORT promotion	Training of 30 GMVs on EBF and diarrhoeal prevention and management at community level
Adult Literacy	Training of 3 AL Committees to support the adult literacy learners and instructors has been planned Follow up visits to the 20 Rural Information Centres to see the progress
Water and Environmental Sanitation	Community mobilisation for refresher training to 15 VHWCs and 5 initial training in HESP and VLOM activities Community motivation to maintain and improve pit latrines with 100 san plats and dome slabs, install 50 hand washing facilities Conduct 15 hygiene education sessions and follow up visits to the trained 40 communities Promote 4 exchange visits for VHWC members and extension workers Community motivation for the construction of garbage pits, bath shelters and dish racks

8.0. SO3 Performance Indicators

Couple Years of Protection

Indicator	1998	1999	2000
Couple Years of Protection	6,450	11,302	12,570

Number of DRFs

Indicator	1998	1999	2000	Total
a) Number of DRFs that are established with USAID funds	0	6	22	22
b) Number of DRFs that are established with other donor's funds and USAID supports their operations	28*	19	21	21
Number of Drug Revolving Funds (DRFs)	22	25	43	43

* Out of the 28 DRFs who were established with other donor's funds in 1998, 6 were inactive and were reactivated in 1999 with USAID funds. Out of the remaining 22 DRFs that were established with other donor's funds, by end of 1999, 6 were inactive and were reactivated in 2000 with USAID funds.
Ten (10) new DRFs were established in 2000 with USAID funds. Cumulative figures

Number of Villages with DRFs:

Indicator	1998	1999	*2000	Total
a) Number of villages with DRFs that are established with USAID funds	0	6	22	22
b) Number of villages with DRFs that are established with other donor's funds and USAID supports their operations	28	19	21	21
c) Number of villages with Drug Revolving Funds (DRFs)	22	25	43	43
d) Estimated number of people benefiting from DRFs	38,500	43,750	78,250	78,250

Note: On average, each DRF centre serves 3 - 5 villages
* Cumulative figures

Number of DRF volunteers:

Indicator	1998	1999	2000	Total
a) Number of volunteers for DRFs that are established with USAID funds	0	15	47	62
b) Number of volunteers for DRFs that are established with other donor's funds and USAID supports for their operations	34	9	6	49
Number of Drug Revolving Funds (DRFs)	34	24	53	111

Indicator	1998	1999	2000	Total
volunteers				

Number of Community Based Distributors of contraceptives (CBDAs)

Indicator	1998	1999	2000	Total
a) Number of active CBDAs providing family planning information, services and reporting that are supported with USAID funds	55	68	98	98
b) Number of primary supervisors	21	28	41	41
c) Number of secondary supervisors	16	16	16	16

Note: All the CBDs were funded with USAID funds. Total number is cumulative

*Water and Environmental Sanitation

Indicator	1998	1999	2000	Total
Estimated number of people gaining access to safe water	35,000	78,714	98,954	98,954
**Estimated number of people with improved sanitary services	729	1,622	5,420	5,420
Number of san plats/dome slab cast	986	3,933	5,900	5,900
Number of san plats/dome slabs used/installed in latrines	729	1,422	4,990	4,990

* Information given is only for the USAID funded activities from 287 villages
**The information was based per household